The Center for Emotional Care
400 East Burwell Street
Salem, VA 24153
540-387-3105

Thank you for choosing The Center for Emotional Care as the provider for your mental health services. We are dedicated to caring for you in a kind, respectful, and professional manner and we hope your experience with us will be both pleasant and beneficial.

With this letter, you will find a *New Patient Information Packet*. Please fill out the packet as completely as possible and mail it back to our office at least seven days prior to your appointment date **or** bring it with you to your initial appointment. (If you do not attend your first appointment or reschedule within 30 days, your Information Packet will be properly destroyed.)

Please arrive **at least 15 minutes** prior to your appointment time with the completed paperwork. If you misplace the paperwork, you must arrive at least 45 minutes prior to your appointment time to complete a new packet. Arriving late may result in your appointment being rescheduled. If you miss the appointment or arrive late you may be charged a fee. Please also read the included *Policies and Procedures* portion of your packet. It contains helpful information about our practice and how we do business. As always, the management, providers and staff are happy to speak with you about any questions or concerns you may have.

How to get to The Center:

- From Interstate 81 take **EXIT 140**
- Take **ROUTE 311 SOUTH** (Thompson Memorial Drive) to Salem
- At the second traffic light turn **RIGHT** onto **Main Street**
- At the next traffic light turn **LEFT** onto **South College Avenue**
- At the next traffic light turn **LEFT** onto **Thompson Memorial Drive**
- Bare **RIGHT** onto **East Burwell Street**
- The Center is located in the tan building on the right behind College Lutheran Church

What to bring with you to each appointment:

1. CURRENT INSURANCE CARD
    - We need an actual copy of your insurance card in order to accurately process your claims. If you do not provide this information you will be financially responsible for the complete cost of your visits.
2. METHOD OF PAYMENT
    - Cash, Check, or Debit/Credit Card (we gladly accept Mastercard and Visa)
3. PHOTO ID
4. ALL PRESCRIPTION MEDICATIONS THE CHILD/ADOLESCENT IS CURRENTLY TAKING

Again, feel free to call us at 540-387-3105 if you have any questions or concerns before your first appointment. Thank you for your confidence and we look forward to serving the needs of you and/or your family.

Sincerely,

Management and Staff
The Center for Emotional Care

The Center for Emotional Care

JUVENILE PATIENT REGISTRATION FORM

(Please Print)

Today's Date:	PCP:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Birth Date: / /	Age:
Is This The Patient's Legal Name? ❑ Yes ❑ No	If Not, What Is The Patient's Legal Name?		Gender: ❑ M ❑ F ❑ Other_____	
Mailing Address:		Social Security #:	Home Phone No.: ( )	
Address Continued:	City:		State:	ZIP Code:
Grade In School:	School Attended:		School Phone No.: ( )	
How Were You Referred To The Center?	❑ Primary Care Physician	❑ Other Doctor/Therapist	❑ Yellow Pages/Telephone Book	Other:_____

Race : ❑ Caucasian ❑ Black or African American ❑ Hispanic ❑ Asian ❑ American Indian or Alaska Native ❑ Other:_____

Preferred Language : ❑ English ❑ Spanish ❑ French ❑ German ❑ Vietnamese ❑ Italian ❑ Mandarin ❑ Other:_____

Ethnicity : ❑ Hispanic or Latino ❑ Other:_____

Person Responsible For Bill:	Birth Date: / /	Address (If Different):	Home Phone No.: ( )
Is This Person A Patient Here? ❑ Yes ❑ No			
Occupation:	Employer:	Employer Address:	Employer Phone No.: ( )
Is This Patient Covered By Insurance? ❑ Yes ❑ No		Does This Patient Have Secondary Insurance Coverage? ❑ Yes ❑ No	
Please Indicate Primary Insurance:			

Subscriber's Name:	Subscriber's S.S. No.:	Birth Date: / /	Group No.:	Policy No.:	Co-Payment: $
Patient's Relationship To Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name Of Local Friend Or Relative (Not Living At Same Address):	Relationship To Patient:	Home Phone No.: ( )	Work Phone No.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Center for Emotional Care, its agents or my insurance company to release any information required to process my claims.

_____ _____

Parent/Legal Guardian signature ***Date***

FINANCIAL AGREEMENT

IF YOU HAVE COMMERCIAL INSURANCE COVERAGE – we will bill most major insurance carriers for you if you provide the necessary information to us. A copy of your insurance card must be provided in advance of your appointment. We will not back-bill insurance after a date of service, even if insurance information is provided at a later date. Co-payments and deductibles are due at the time of service. Coinsurance will be billed to you once payment is received from your insurance carrier. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If your insurance carrier has not paid within 60 days of billing, any outstanding fees will become due and payable by you.

Assignment of Commercial Insurance Benefits

I hereby assign all health benefits, private insurance, and any other health plans to The Center for Emotional Care and request payment of benefits be made to them on my behalf. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges regardless of whether payment is made by my insurance company. I authorize The Center for Emotional Care to release any information necessary to secure payment for services provided to me.

IF YOU HAVE MEDICARE INSURANCE COVERAGE – we will bill Medicare for you. We will also bill any secondary insurance carrier. Co-payments and deductibles are due at the time of service. Coinsurance will be billed to you once payment is received from your insurance carrier.

Assignment of Medicare Insurance Benefits

I hereby request payment of all Medicare benefits be made on my behalf to The Center for Emotional Care for any services provided to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

NON-COVERED SERVICES – Any services not paid for by your insurance coverage will require payment in full at the time of service or upon notice of insurance claim denial.

PATIENTS WITHOUT INSURANCE COVERAGE – Lack of insurance coverage will in no way affect the availability or level of care provided to you. By signing below, patients without insurance coverage agree to pay the total amount due on each date of service.

PAYMENT OF OUTSTANDING BALANCES - You are responsible for co-payments or other charges at the time of service. However, coinsurance amounts will often not be reflected on your statement until the following billing cycle. Each month we mail billing statements for each account with balances due. You are responsible for paying the total amount due upon receipt of the statement. If we do not receive payment in full for balances due within 30 days of billing, we will begin collection procedures. Outstanding balances exceeding 60 days past due may result in the suspension of services. Seriously delinquent accounts will be referred to a professional collection agency or the Internal Revenue Service for collection. In the event that your account is forwarded to an external collection agency, any collection fees will be added to your total amount due. You agree that in order for us to service the account or to collect any amounts you may owe, we/or the collection agency may contact you by telephone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We or/collection agency may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

SIGNATURE

By signing below, I attest that I have read, understand and will agree to The Center for Emotional Care's financial policies regarding payment for services rendered, including all policies outlined in the Policies and Procedures Packet. By signing I agree to be financially responsible for any and all professional fees.

Patient Name:	
Parent/Legal Guardian's Name:	_____
Parent/Legal Guardian's Signature:	_____
Insurance Subscriber's Name (if different):	_____

INFORMED CONSENT FOR TREATMENT

Patient Name:		**Date of Birth:**	

By signing below, I hereby give permission to The Center for Emotional Care to provide treatment/testing to the person named above. This will include discussion of tentative diagnosis, methods and modalities to be used in treatment, and possible outcomes. I understand that treatment outcomes cannot be guaranteed, and that treatment can at times be painful and difficult. I understand that I may withdraw from treatment at any time, but I agree to discuss my plan with my therapist/doctor before doing so. I further agree to take medication as prescribed, and will inform my doctor of any side effects immediately.

I further acknowledge that I have read and understand the Policies and Procedures, and that I understand the limits of confidentiality regarding treatment, and the office policies regarding scheduling, emergency coverage, fees and billing, insurance filing, missed appointments, court appearances, copying records, phone consultations, etc… I acknowledge my understanding of and my willingness to abide by these policies and procedures by my signature below.

SIGNATURES

Parent/Legal Guardian Signature	***Date***
Witness Signature	***Date***

MEDICAL HISTORY/INFORMATION

Briefly state the reason you would like your child to see a Psychiatrist/Therapist:	

Primary Care Physician:	Facility:	Phone Number:
Other Psychiatrist/Therapist:	Facility:	Phone Number:

Is your child presently taking any prescription medications?	❑ YES	❑ NO

If yes, please list them below:

Medication:	Dosage:	How long has the child taken it:	Prescribing Doctor:

Height:	Weight:	When was your child's last medical exam?	
Do you smoke? ❑ YES ❑ NO	If so, how much?		
Has your child ever had a head injury? Do you have any medication allergies ❑ YES ❑ NO	If so, when? If so, which?	Has your child ever had a seizure?	If so, when?
Has your child previously been treated by a psychiatrist? ❑ YES ❑ NO	If so, when?	Briefly describe the reason:	
Has your child previously been treated by a therapist? ❑ YES ❑ NO	If so, when?	Briefly describe the reason:	
Has your child ever been hospitalized for psychiatric reasons? ❑ YES ❑ NO	If so, when?	Briefly describe the reason:	

FAMILY HISTORY/INFORMATION

Father's Name:	❑ Living	Occupation:	Age:
	❑ Deceased	Cause of Death:	Age at time of Death:
Mother's Name:	❑ Living	Occupation:	Age:
	❑ Deceased	Cause of Death:	Age at time of Death:

Are the child's parents divorced or separated?	❑ YES	❑ NO	If yes, what age was the child when they separated?
If the parents are separated, who has primary custody?			

List any siblings and their ages:	Name:	Age:	Relationship (biological, half, step, adopted, foster:
List all current members of the child's			

household:			

FAMILY HISTORY/INFORMATION CONTINUED

Please check all that apply:

	FATHER	MOTHER	SIBLINGS	GRANDPARENTS
Alcoholism	❑	❑	❑	❑
Drug Abuse	❑	❑	❑	❑
Depression	❑	❑	❑	❑
Manic Depression	❑	❑	❑	❑
Anxiety	❑	❑	❑	❑
Suicide	❑	❑	❑	❑
ADHD	❑	❑	❑	❑
Obsessive/Compulsive Disorder	❑	❑	❑	❑
Eating Disorder	❑	❑	❑	❑
Other Disorders	❑	❑	❑	❑

Does your child have a history of physical, verbal, or sexual abuse?			❑ YES	❑ NO
If yes, please explain:				
Does your child have a history of legal difficulties?			❑ YES	❑ NO
If yes, please explain:				

DEVELOPMENTAL HISTORY

During pregnancy, was there any bleeding?			❑ YES	❑ NO
During pregnancy, was there a problem with high blood pressure?			❑ YES	❑ NO
Please check any substances that were used during pregnancy:				
❑ Tobacco	❑ Alcohol	❑ Illegal Drugs	❑ Prescription Medications	❑ Other
If any are checked, Please explain:				
Did the Mother suffer any illness during pregnancy?				
Were there any other difficulties during pregnancy?				
Was the pregnancy full term?			❑ YES	❑ NO
If premature, how many weeks?				
Type of delivery:		❑ Normal	❑ Cesarean	❑ Breech
Birth Weight:	Length of Labor:		Condition of child at birth:	
Was oxygen given at birth?			❑ YES	❑ NO
At what age did your child:	Walk alone:	Use single words:	Form sentences:	Toilet train:
Has your child ever had an eye and/or hearing exam?			❑ YES	❑ NO
If yes, what were the results?				
Has your child experienced a head injury?			❑ YES	❑ NO
If yes, please explain:				
Has your child experienced a loss of consciousness?			❑ YES	❑ NO
If yes, please explain:				
Was your child adopted?			❑ YES	❑ NO
If yes, at what age:		Does your child know?	❑ YES	❑ NO
Has your child ever been separated from either parent?			❑ YES	❑ NO
If yes, please explain:				

LEGAL HISTORY

Has your child been involved with the police or juvenile court system?	❑ YES	❑ NO
If yes, please explain:		

SCHOOL HISTORY

School Currently Attending:		Grade:
Previous Schools Attended:		Grades:
		Grades:

School Attendance Record:	❑ Excellent	❑ Good	❑ Poor
Has your child experienced any problems academically?		❑ YES	❑ NO
If yes, please explain:			
Has your child repeated any grades?		❑ YES	❑ NO
If yes, please explain:			
Has your child experienced any social problems at school?		❑ YES	❑ NO
If yes, please explain:			
Has your child had detention?		❑ YES	❑ NO
If yes, please explain:			
Has your child had suspension?		❑ YES	❑ NO
If yes, please explain:			
Has your child experienced any traumatic experiences related to school?		❑ YES	❑ NO
If yes, please explain:			
Has your child had psychological testing?		❑ YES	❑ NO
If yes, when:	Where:		
Has your child ever had special education services?		❑ YES	❑ NO
If yes, please explain:			
Is your child currently in special education?		❑ YES	❑ NO
If yes, please explain:			

SUBSTANCE ABUSE HISTORY

Please check all that apply:

SUBSTANCE	History of use?		Age of first use:	Date of last use:	Use within the past year?	
Alcohol	❑ YES	❑ NO			❑ YES	❑ NO
Barbiturates	❑ YES	❑ NO			❑ YES	❑ NO
Xanax, Valium, Librium	❑ YES	❑ NO			❑ YES	❑ NO
Cocaine, Crack	❑ YES	❑ NO			❑ YES	❑ NO
Heroin, Opiates	❑ YES	❑ NO			❑ YES	❑ NO
Marijuana	❑ YES	❑ NO			❑ YES	❑ NO
PCP, LSD Mescaline	❑ YES	❑ NO			❑ YES	❑ NO
Inhalants	❑ YES	❑ NO			❑ YES	❑ NO
Caffeine	❑ YES	❑ NO			❑ YES	❑ NO
Nicotine	❑ YES	❑ NO			❑ YES	❑ NO
Amphetamines, Speed, Uppers, Crystal Meth	❑ YES	❑ NO			❑ YES	❑ NO
Designer Drugs, Ecstasy	❑ YES	❑ NO			❑ YES	❑ NO

Over-the-counter drugs	❑ YES	❑ NO			❑ YES	❑ NO
If your child currently uses any of the above substances, please describe when and where you typically use:						
If your child currently uses any of the above substances, please describe how it has affected your family and friends, including how they perceive her/his use:						
If your child currently uses any of the above substances, how does she/he perceive her/his use?						
Has your child ever received substance abuse treatment?					❑ YES	❑ NO
Has your child ever had:	❑ Blackouts	❑ DUI	❑ Seizures	❑ Tremors	❑ Legal Charges	❑ Hallucinations

REPORT OF CURRENT AND PAST SYMPTOMS

Please check any problems that your child either has had in the past or is currently having.

Current	Past		Current	Past	
❑	❑	Obsess about checking, counting/or washing hands	❑	❑	Hear voices
❑	❑	Feel people are after you, against you, following you	❑	❑	Unusual thinking
❑	❑	Odd speech/thinking	❑	❑	Not interested in making friends
❑	❑	Fear of becoming fat	❑	❑	Engage in self-induced vomiting
❑	❑	Gorging on food	❑	❑	Excessive dieting/exercise
❑	❑	Use laxatives	❑	❑	Eat things that are not food
❑	❑	Shy	❑	❑	Expect failure
❑	❑	Selfish	❑	❑	Lazy
❑	❑	Avoid adults	❑	❑	Easy Going
❑	❑	Friendly	❑	❑	Enthusiastic
❑	❑	Slow moving	❑	❑	Easily embarrassed
❑	❑	Few close friends	❑	❑	Lack of responsiveness to others
❑	❑	Messy	❑	❑	Careless, reckless
❑	❑	Learning difficulties	❑	❑	Difficulty paying attention
❑	❑	Disorganized	❑	❑	Fidgety, restless, overactive
❑	❑	Talking/acting without thinking	❑	❑	Short attention span
❑	❑	Frequent daydreams	❑	❑	Self-mutilation
❑	❑	Bored easily	❑	❑	Vandalism
❑	❑	Fire-setting	❑	❑	Nightmares
❑	❑	Afraid to leave a loved one	❑	❑	Fear of strangers
❑	❑	Often sick on school/work days	❑	❑	Refusing to talk
❑	❑	Defiant of authority	❑	❑	Often disobedient
❑	❑	Argumentative	❑	❑	Upset of minor changes
❑	❑	Stubborn	❑	❑	Temper tantrums/Sudden anger
❑	❑	Lack of guilt over wrong doing	❑	❑	Bullies others
❑	❑	Sexually acting out	❑	❑	Lying
❑	❑	Truancy	❑	❑	Physically aggressive toward others
❑	❑	Theft	❑	❑	Lack self-confidence
❑	❑	Problems with long-term memory	❑	❑	Problems with short-term memory

ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES – In keeping with the provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), The Center for Emotional Care has provided a "Notice of Privacy Practices" to me. By signing below, I acknowledge that I have received, read, and understand this notice.

POLICIES AND PROCEDURES – By signing below, I acknowledge that I have received a copy of The Center for Emotional Care's "Policies and Procedures" and attest that I have read, understand, and will abide by all policies and procedures as outlined.

AUTHORIZATION TO RECEIVE REMINDER CALLS

The Center for Emotional Care provides reminder calls as a courtesy to all patients on the business day previous to their scheduled appointment. In keeping with the provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), The Center for Emotional Care must retain your permission before providing this courtesy service.

By accepting this service and signing below, you are giving The Center for Emotional Care permission to give you a reminder call, including permission to leave a message on your answering machine/voice mail, or with anyone who might answer your telephone. If you do not wish to receive this courtesy service, please select the "decline" option below.

❑	**ACCEPT:** "I would like to receive reminder calls and give permission to The Center for Emotional Care to leave a message for me if I am unavailable."
❑	**DECLINE:** "I would **NOT** like to receive reminder calls and do **NOT** give permission to The Center for Emotional Care to leave a message for me if I am unavailable."

REQUIRED SIGNATURES

Signature of Patient or Legal Guardian ***Date***

Printed Name of Person Signing

Witness ***Date***

The Center for Emotional Care
400 East Burwell Street
Salem, Virginia 24153
Phone: (540) 387-3105 Fax: (540) 387-3653

E-PRESCRIBING CONSENT FORM

E-Prescribing is defined as a provider's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

· **Formulary and benefit transactions** – Gives the prescriber information about which drugs are
covered by the drug benefit plan.

· **Medication history transactions** – Provides the prescriber with information about medications
the patient is already taking to minimize the number of adverse drug events.

· **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that The Center for Emotional Care can request and use your prescription medication history from other health providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all the above, I hereby provide informed consent to The Center for Emotional Care to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____
Name of Patient Patient's DOB

_____ _____
Signature of Patient or Guardian Date

Relationship to Patient: _____

The Center for Emotional Care
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Salem, VA 24153
Phone: 540-387-3105 ~ Fax: 540-387-3653

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Virginia Prescription Monitoring Program

Patient Name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize providers at The Center for Emotional Care to request and receive any and all records held by the Virginia Department of Health Professions relating to any and all substances dispensed to the patient named above. I understand that this authorization permits the Department of Health Professions to disclose confidential health care records to The Center for Emotional Care.

I authorize the providers at The Center for Emotional Care to re-release information obtained through the Department of Health Professions to any and all of my treating providers.

I understand that I may refuse to sign this release or revoke this consent at any time, except to the extent that information has already been released, and that this consent will expire at discharge, unless specified differently on this form. I further understand that if I refuse to sign this release or revoke my consent that providers at The Center for Emotional Care may decide not to prescribe addictive substances.

A copy of this authorization shall be included with my original records.

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date

The Center for Emotional Care
400 East Burwell Street, Salem, VA 24153
Phone: 540-387-3105 Fax: 540-387-3653

Authorization to Use or Disclose My Health Information

Patient Name: _____ DOB: _____

Patient Address: _____
(Street) (City) (State) (Zip)

Information is to be □ exchanged with or □ released from Providers of The Center for Emotional Care and:

Please fill Out for Primary Care Physician
Name/Agency: _____
Street Address: _____
City, State, Zip: _____
Phone/Fax Numbers: _____

Purpose of Release: □ Diagnosis/Treatment □ Communication □ Legal Representation □ Continuity of Care
□ Other: _____

Reason(s) for this authorization (check all that apply):
□ At my request
□ Other (specify): _____

Extent or nature of use/disclosure is limited to: (Check or list all that apply)

□ Psychiatric Records □ Alcohol Abuse Treatment Information □ Verbal Treatment Information
□ Psychotherapy Notes □ Drug Abuse Treatment Information □ HIV/AIDS Information
□ Lab Results □ Psychiatric Test Results □ Consultations
□ Any and all health information maintained by The Center for Emotional Care
□ Other: _____

The recipient is authorized to use the information received pursuant to this authorization. As the person signing this authorization, I acknowledge that I am giving my permission to the above-named person to disclose or obtain protected health information. I further acknowledge that:

· I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
· The original or a copy of this authorization shall be included with my original records.
· I have the right to revoke this authorization at any time, except to the extent that action has been taken on it, by delivering the revocation in writing to the provider who is in possession of my health care records.
· There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule. If this information is being disclosed from records protected by the Federal substance abuse confidentiality rules (42 CFR Part 2), the Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

If not previously revoked, this authorization will expire in: □ One year; □ On (specify date): _____

_____ _____ _____
Signature of Adult Patient or Legally Authorized Representative Relationship Date Signed

_____ _____
Signature of Minor Patient (if 14 or older) Date Signed